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LETTERS

DEPRESSION SEVERITY SCORES

Not all that weeps is depression

Doctors listening to the chests of patients with left ventricular failure will remember that not all that wheezes is asthma. Similarly, when low mood strikes our patients we need to remember that not all that weeps is depression. Adjustment disorders, bereavement, dysthymia, and borderline personality traits can all present with low mood, and are not depression but are easily mislabelled.

The hospital anxiety and depression scale (HADS), Beck depression inventory (BDI), and 9 item patient health questionnaire (PHQ-9) are all markers of the severity of depression.[1] PHQ-9 and HAD are also screening tools to judge the probability that depression is present. They are not diagnostic tools. In particular the fragile labile mood and need for instant relief because of low frustration tolerance that feature in borderline personality traits can give very odd results with these tools. Often the score is heavily shifted to the severe end.

In the study by Kendrick and colleagues no attempt seems to have been made to establish the diagnosis for the patients given the tools, other than that they were given them. We need to use diagnostic labels carefully, and certainly avoid the easy trap of low mood is depression needs counselling.

Petre T C Jones general practitioner, The Project Surgery, London E13 0LN **Petre.JOnes@gp-f84750.nhs.uk**

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1 Kendrick T, Dowrick C, McBride A, Howe A, Clarke P, Maisey S, et al. Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *BMJ* 2009;338:b750. (19 March.)

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Questionnaires are good for rating progress

Kendrick and colleagues compared scores on the severity of depression with the rate of referral to the psychiatric services and prescription of antidepressants.[1] At face value, responders to the 9 item patient health questionnaire (PHQ-9) seem to have falsely alerted the clinicians to act in a more aggressive manner.

It may be a false assumption. The incidence is likely to be higher among those who responded

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to the PHQ-9. The comparison at baseline shows a higher proportion of chronic physical illnesses among this group: 50% higher than in the hospital anxiety and depression scale (HAD) group. This alone could be the reason for the disparity in severity assessment.

Debate over the suitability of questionnaires may never be settled as more new questionnaires are produced to assess depression. The ideal use of questionnaires, however, is to measure progress. To assess improvement, any of the three validated questionnaires is acceptable.

Gnanie Panch consultant, Chronic Pain Service, Whittington Hospital, London N19 5NF **gnanie.panch@whittington.nhs.uk**

Competing interests: None declared.

1 Kendrick T, Dowrick C, McBride A, Howe A, Clarke P, Maisey S, et al. Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *BMJ* 2009;338:b750. (19 March.)

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SHARING MEDICAL RESEARCH DATA

Whose rights and who's right?

The moral tone of Groves' editorial—research is publicly funded; fellow scientists and citizens have a "right" to access "raw numbers, analyses, facts, ideas, and images"; some naughty researchers are colluding with industry to "keep the data hidden away"—was inappropriate.[1]

Firstly, an increasing number of journal editors are making naive assumptions about the nature of research knowledge. A proportion of such knowledge—for example, in basic sciences—can legitimately be treated as "facts" or "raw numbers" that can be extracted from their context and analysed unproblematically by others at some future date. But the data behind most *BMJ* papers (broadly, health services research) is not so cleanly cleaved from the context in which it was collected or the people who supplied it and interpreted it. There is an important literature on the lack of transferability of knowledge between communities even in the basic sciences.[2 3] The problem increases as the unit of analysis moves from the base pair to the healthcare organisation.[4 5]

Secondly, the delicate trust relationship between researchers and research participants is under threat. It is one thing to agree to give an interview (or a tissue sample) to a researcher on the assurance that the raw data will be carefully protected and destroyed once the analysis is complete. It is quite another to agree to the passing of one's data to unknown others for unknown future purposes. Neither scientists nor the general public have a "right" to access these data just because the work was publicly funded. Research ethics committees typically require the destruction of data such as audiotapes within three years of collection.

Thirdly, I thought we had moved on from the GOBSAT (good old boys sat around a table) method of developing guidelines, especially when the good old boys and girls were all selected from the "ayes" rather than the "nays."

Trisha Greenhalgh professor of primary health care, University College London **p.greenhalgh@ucl.ac.uk**

Competing interests: TG is a researcher who has ethical obligations to people who supplied data to her.

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TESTS FOR HIV INFECTION

Current screening for HIV

Doctors should recommend men who have sex with men be tested regularly for HIV infection, but suggesting that doctors should demand antigen tests and genomic testing instead of antibody tests is inaccurate.[1]

The current fourth generation screening assays permit the simultaneous detection of HIV P24 antigen and antibody and have reduced the diagnostic window between the time of HIV infection and laboratory diagnosis significantly (27.4 days).[2] Genomic testing in the form of HIV quantitative assays (viral load

tests) should be considered only in suspected primary HIV infection. The fourth generation assay is as effective as genomic testing in identifying acute HIV infection.[3]

In addition, plasma viral load assays have been designed to monitor response to treatment in people with known HIV infection and not to diagnose HIV infection. Viral load tests are vulnerable to false positive results, which are potentially devastating for patients. The UK guidelines for HIV testing recommend fourth generation assays as firstline screening.[4] In cases of suspected primary HIV infection either urgent referral to specialist services or a repeat test in seven days is recommended.

Jaime H Vera academic clinical fellow, genitourinary and HIV medicine, St Mary's Hospital NHS Trust, Imperial College, London W2 1NY **jvera@imperial.ac.uk**
Andrew Shaw consultant, genitourinary and HIV medicine, Northwick Park Hospital, Harrow, Middlesex HA1 3UJ

Competing interests: None declared.

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ADVERSE REACTIONS TO TOCOLYTICS

Atosiban *v* nifedipine

De Heus and colleagues conclude that oxytocin antagonists and calcium channel blockers should be compared for tocolytic efficiency and side effects.[1]

Two (small) randomised controlled trials comparing atosiban and nifedipine have been published.[2 3] Pooling their data on tocolysis before 35 weeks' gestation yields 71 women given atosiban and 72 nifedipine, delivery being postponed in 57 and 56 respectively (P=0.713, odds ratio 1.08, 95% confidence interval 0.71 to 1.65). Side effects such as arterial hypotension occurred in 1 woman given atosiban and 25 given nifedipine (P<0.001, odds ratio 16.7, 2.43 to 115.9).

Yves Jacquemyn head, Department of Obstetrics and Gynaecology, Antwerp University Hospital, Wilrijkstraat 10, 2650 Edegem, Belgium **yves.jacquemyn@uza.be**

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1 De Heus R, Mol BW, Erwich JJ, van Geijn HP, Gyselaers WJ, Hanssens M, et al. Adverse drug reactions to tocolytic treatment for preterm labour: prospective cohort study. *BMJ* 2009;338:b744. (5 March.)
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No to β agonists for tocolysis

That β agonists were still used for tocolysis in 2006-7, given their potentially serious side effects on maternal cardiovascular function, is surprising.[1] Indeed calcium channel blockers and atosiban are at least as effective as β agonists with fewer severe side effects.[2]

In addition, antenatal indomethacin, described as having no severe maternal side effects,[1] may be associated with severe neonatal outcomes such as periventricular leukomalacia and necrotising enterocolitis.[3]

Souhail Alouini obstetrician and gynaecologist, Centre Hospitalier Regional d'Orléans, 45000 Orleans, France
alouini.s@wanadoo.fr

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CARE IN LEARNING DISABILITIES

People with disabilities are not equal from the start

The ombudsman's report on complaints about the care of six people with learning disabilities who died while in hospital[1] says that their treatment was "a shocking indictment of services which profess to value individuals and to personalise services according to individual need." It also says that they were treated "less favourably than others, resulting in prolonged suffering and inappropriate care." Shocking, indeed.

Recently, the *BMJ* published an editorial and research papers about screening for Down's syndrome.[2] They discuss ways of screening pregnant women and describe the difficulties in deciding whom should be offered what sort of screening and how to make use of the results.

The introduction to a recent strategy document signed by six secretaries of state begins: "People with learning disabilities are entitled to the same aspirations and life chances as other people."[3] But how can people with learning disabilities get the same life chances as other people when the NHS seeks out some of them before birth and the law allows them to be aborted up to term?

The Disability Discrimination Act 2005 requires public authorities to promote positive attitudes towards disabled people. The NHS is a public authority so, arguably, in providing a prenatal screening service for Down's syndrome it is not promoting positive attitudes towards disabled people. Therefore, should we be surprised that there is evidence that the NHS treats patients with Down's syndrome "less favourably than others"?[1]

Joyce M Carter consultant in public health medicine, Liverpool L1 4AZ **joyce.carter@liverpoolpct.nhs.uk**

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THE POPE, CONDOMS, AND HIV

Why the Pope may be right

Kamerow asserts that "ABC" (abstain, be faithful, condom use) in Uganda probably owed most of its effectiveness to greater use of condoms.[1] This is contradicted in several papers.[2-4] In one the government clearly communicated that AIDS was fatal and required immediate population responses based on faithfulness to one partner, condoms being a minor component of its strategy.[2]

Indeed, Edward Green, director of the AIDS Prevention Research Project at Harvard, agreed with the Pope[5]:

> The best evidence we have shows that condoms do not work as an intervention intended to reduce HIV infection rates in Africa ... What we see in fact is an association between greater condom use and higher infection rates ... We are seeing HIV decline in at least 8 or 9 countries in Africa. In every case the proportion of men and women reporting multiple sexual partners has decreased a few years before we see the decline. Yet most AIDS programs emphasise condoms, testing, and drugs.

Anthony McCarthy research fellow, Linacre Centre for Healthcare Ethics, London NW8 9SE **a.mccarthy@linacre.org**

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